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## “Calming Watercolors”: Using Mindful Art in Treatment of Mood Disorders

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Running Head: CALMING WATERCOLORS, USING MINDFUL ART IN AN INPATIENT SETTING

“Calming Watercolors”: Using Mindful Art in Treatment of Mood Disorders, Development of a

Method

Capstone Thesis

Lesley University

May 5, 2020

Patrick MacLeod

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## CALMING WATERCOLORS

**Abstract**

Art and mindfulness serve as separate approaches for both mental health treatment and relaxation. This thesis aimed to explore the meaning of a mindfulness-based art directive as perceived by individuals dealing with mood disorders, and its possible influence on their levels of mood and anxiety. The history of mindfulness and expressive therapies are explored, and the benefits of each approach are highlighted. Dialectical Behavioral Therapy, Mindfulness Based Stress Reduction and Mindfulness Based Cognitive Therapy are discussed as ways to enhance the relationship between mind and body, to reduce the suffering that comes from mental and physical pains, and to prevent depressive relapse.

In order to examine the influences of mindful art as an integrated approach, I developed a mindfulness-based art directive, administered to patients diagnosed with Major Depressive Disorder in a short-term inpatient psychiatric hospital unit. Participants were asked to assess their mood and anxiety before participating in a mindfulness activity followed by an arts-based directive. After the directive, participants were asked to reassess their mood and anxiety and to note any change. In addition, the participants shared their experience, thoughts and feelings regarding the directive. The analysis of the participants' experiences gave rise to themes, such as "Mindfulness induced anxiety", "The significance of watercolors", "The intermodal affect" and "The choice of color". In addition, the participants' self-reports imply that the combination of mindfulness and art had a positive impact on mood.

This study offers insight into arts and mindfulness as well as supporting the idea that the arts can serve as a complimentary piece to mindfulness-based interventions. Finally,

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recommendations for improving the directive and further research are delineated, mostly concentrating population size and the use of artistic medium.

### **Introduction**

The world of pop culture, as well as, the world of medicine and healthcare have seen an increase in the topic of mindfulness and its beneficial applications (Nilsson, H., & Kazemi, A, 2016). However, most of the research readily available on databases is either related exclusively to mindfulness or to art making. This is evident by conducting a search on the Lesley University database: while using the key terms “mindfulness” and “art therapy” together resulted in a total of 575 scholarly articles and books, a search of either individually garnered thousands of articles on the same database. Additionally, there are varying definitions of what mindfulness is, that ultimately alters how it may be therapeutically applied. If the application of mindfulness and art making combined can have an influence on mood, it could be used as a beneficial coping skill for patients, as well as offering a reprieve from some of the adverse symptoms of mood disorders.

One area that Mindfulness has become increasingly integrated into is the field of therapy. Many major contemporary therapeutic approaches have incorporated Mindfulness, including Dialectical Behavioral Therapy (DBT) (Linehan, 1993), Cognitive Behavioral Therapy (CBT) (Barnard & Teasdale, 1991), and Acceptance and Commitment Therapy (ACT) (Hayes, Strosahl & Wilson 2012). Within the practice of Dialectical Behavioral Therapy (Linehan,1993) and Acceptance Commitment Therapy (Hayes et al., 2012) Mindfulness is utilized as a guiding core principal. These theories acknowledge that often individuals are either too close or too far from their emotions and, mindfulness as a skill in turn allows the individual to take a step back and

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acknowledge the reality of the situation free from emotion (Barnard & Teasdale, 1991; Hayes, Strosahl & Wilson 2012; Linehan, 1993).

Several expressive therapists have reported their using of mindfulness in their work (Rappoport, 2009; Rogers, 1993). Natalie Rogers (1993) expanded Person-Centered therapy (1959) to include the arts and mindfulness in the therapy process. Rogers (1993) proposed that art in any form can be a powerful tool to helping an individual understand themselves more fully. In order to do this, she explains, one must do their best to suppress their judgement of themselves and their work. In this sense Rogers (1993) is asking individuals to be present in the moment of creation and focus on the process rather than on the product.

In the past ten years, Laury Rappaport (2009) continued to utilize mindfulness in her work with Focus Oriented Art Therapy (FOAT). In FOAT the client uses the bodies' inherent way of knowing to express its needs in the moment, in order to resolve conflict, or ease the mind of potential stressors (Rappaport, 2009). This is achieved by doing a "check in", which is very similar to meditation, where the individual calms their breathing and focuses on body sensations or mental images in the present moment (Rappaport, 2009). Through this process the client can observe and experience their inner world nonjudgmentally in a safe atmosphere.

All of the aforementioned theories ( Barnard & Teasdale, 1991; Hayes, Strosahl & Wilson 2012; Linehan, 1993; Rappaport, 2009; Rogers, 1993) use mindfulness in art therapy, which is enhanced through the practice of art making to produce insight (Rappoport, 2009; Rogers, 1993). However, the ability to focus on mindfulness may not be entirely feasible to those living with a mental health condition, even if the result is beneficial to the symptomology. Therefore, I presume that if a patient can ground themselves through mindfulness, they may be

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more likely to engage in art making, which will potentially affect their mood. Art therapy has been used in a variety of populations ranging from children to adults. However, the use of the Arts in conjunction with mindfulness and in the treatment of varied symptoms and diagnoses in a clinical setting has not been fully explored. Particularly the use of mindful art with individuals diagnosed with Depression and Anxiety, while in a clinical setting.

According to the DSM-V some of the primary symptoms of depression are rumination, thoughts and feelings of worthlessness, as well as guilt and loss of interest in previously enjoyed activities (American Psychiatric Association, 2017). The symptom of rumination, or getting stuck in a thought loop, can distract heavily from the present moment. If an individual is not able to concentrate in the moment their ability to notice and experience reality as it is, may be heavily impaired. Likewise, the primary symptoms of Anxiety are difficulty concentrating, irritability, and an inability to control worry (American Psychiatric Association, 2017). Just like the symptoms of depression, anxiety heavily detracts from experiencing the present moment. Being able to acknowledge the present moment is a key element of mindfulness, therefore it seems that someone living with Depression or Anxiety would be at a disadvantage to practicing mindfulness. Incorporating the arts into the practice of mindfulness may help to bring the attention to the present moment.

My interest in mindfulness stems from an everyday practice of self-reflection, particularly through meditation and the act of creation in art making. The aim of this thesis is to explore how mindful creation of art can be applied to those living with mood disorders in a clinical setting, particularly adults. I am interested to see if art making when combined with mindful techniques will influence the mood of those participating.

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My intervention will consist of asking adults in a psychiatric hospital to practice mindfulness through art making. Prior to creating art, participants will be led through a grounding meditation. Patients will then be encouraged to paint using watercolors, while being guided by a mindfulness script which will be read aloud by the facilitator. The facilitator in this setting being myself. In addition to the prompt, calming background music will be playing; collectively these stimuli may help to give participants several things to focus on while they work, as opposed to focusing in on their thoughts or ruminations. Participants will be asked to evaluate their mood and anxiety prior to beginning the directive in the form of a check in. Additionally, they will be asked about their mood and anxiety following the directive, as well as engaging in an open dialogue with other participants and the facilitator. In order to keep track of my own mood and thought process I will also keep a researcher's journal; in this journal I will create artwork and take notes on what has been done in session. By doing this I will be adding an Arts-Based Research (McNiff, 1998) approach to my directive, as well as highlighting emergent themes as the research progresses.

In Conclusion, this research will aim to improve and expand on the existing limited research of expressive therapies, mindfulness, and psychopathology in treatment of mood disorders. If the application of mindfulness and art making combined can have an influence on mood, it could be used as beneficial coping skill for patients, as well as offering a reprieve from some of the adverse symptoms of mood disorders. This research will also help to expand upon the small amount of research that is available relating to mindful art making with adults in a clinical inpatient setting. In this thesis I will explore literature relating to several topics, the first being the history and applications of mindfulness and art. The second portion of this thesis will describe my intervention as well as its results.

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### **Literature Review**

#### **Mood Disorder**

Mood disorder is a broad definition given to a variety of diagnoses that cause a disruption in an individual's mood and functions that are affected by mood (Dimaria, 2020). Mood disorders are commonly split into two diagnoses based on symptomology, Major Depressive Disorder and Bipolar Disorder. Major Depressive Disorder is an example of diagnosis that is characterized primarily by extensive periods of intense sadness, fatigue or tiredness, as well as a sense of hopelessness (Dimaria, 2020). The length of a depressive episode is variable and can range anywhere from two weeks to several months (Dimaria, 2020). The current standard treatment of mood disorders consists of psychotherapy alongside the prescription of pharmaceuticals in order to treat any chemical imbalances that may be present and attributing to the symptoms as well as to stabilize mood (Dimaria, 2020). While these treatments are effective for some, the need for supplementary treatment for alleviation and reduction of symptoms of stress and anxiety is highly present. One of the focuses of this work will be mindfulness and its application for mood disorders. Prior to exploring the therapeutic aspects of Mindfulness, I will begin with elaborating on the its historical origins.

#### **Historical Context of Mindfulness**

In order to understand the therapeutic applications of Mindfulness it is important to understand the cultural and historical context that created the practice. Furthermore, it would be inappropriate to not acknowledge the cultures and application that gave birth to mindfulness which has become incorporated into our modern understanding of contemporary psychotherapy. Mindfulness is an idea and practice that first originated in Northern India approximately 2,500



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years ago and then stemmed out of the Buddhist tradition through the teachings of Siddhartha Gautama (Kang & Whittingham, 2010). Given that Buddhism as a religion accounts for about 7% of the world's population (Pew Research Center, 2012) there are a variety of different forms that help to define and give context for what mindfulness is (Kang & Whittingham, 2010). An article defining the major schools of Buddhism and the applications of mindfulness by Kang & Whittingham (2010) states that Theravada, Mahayana, and Vajrayana are the three major schools of Buddhism today.

Each school is specific to a region of the Asian continent. Theravada being prominent in Thailand, Sri Lanka, Burma, and Cambodia (Kang & Whittingham, 2010). Theravada Buddhism, chronologically, has the closest foundation relevant to the time that Siddhartha Gautama was beginning to implement his teachings. Due to this, in some circles Theravada Buddhism is sometimes considered to be the closest practice to what the Buddha intended his teachings to be used for (Kang & Whittingham, 2010). According to Bodhi (2000) Theravada Buddhism describes mindfulness as a “simple awareness”. The concept is to be able to reach a simple awareness, and then not attaching or focusing on observations or thoughts that enter the mind during meditation. (Bodhi, 2000).

The Mahayana approach to Buddhism is popular in regions such as China and Japan (Kang & Whittingham, 2010). This school of Buddhism has forms that may be more familiar to those living in the western hemisphere, such as Zen Buddhism and Tibetan Buddhism (Kang & Whittingham, 2010). The Mahayana school describes mindfulness as “a simple awareness sustained exclusively and keenly on one focal object without cognitive interruption or distraction over a period. (Kang & Whittingham, 2010, p.166).” Kang & Whittingham (2010) note that the

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Mahayana practice of mindfulness attempts to rid the mind of “false thoughts” or ideas, conceptions, or distractions from the tangible reality. Both approaches to mindfulness relate to my thesis directive. In this directive the Art making will serve as the participants’ focal point and the catalyst to a simple awareness of the present moment.

Lastly there is the Vajrayana school. It is important to note that the Vajrayana school is not necessarily an independent approach to Buddhism, but rather the result of the Mahayana and Theravada blending (Kang & Whittingham, 2010). Despite these schools forming in different regions and time periods, all three contain the building blocks of what today would be called mindfulness.

In Conclusion all these schools of thought, show us that mindfulness requires a present moment awareness, a non-judgmental stance in thought, and a detachment from emotions or thoughts in our mind that detract from the physical reality of our present moment. Additionally, mindfulness can be accompanied by a focal point or grounding tool, as was explained in the Mahayana practice (Kang & Whittingham, 2010). Before examining how these different approaches to mindfulness work congruently with the expressive therapies, it is also important to explore other therapeutic applications of mindfulness.

### **Therapeutic Applications of Mindfulness**

Mindfulness has been applied to a variety of therapeutic approaches (Barnard & Teasdale, 1991; Hayes, Strosahl & Wilson 2012; Linehan, 1993), for a multitude of different reasons. As previously discussed, mindfulness can be used to bring an awareness to the present moment (Daphne M. Davis and Jeffery A. Hayes, 2011), however many of the major contemporary theories have fine-tuned the definition and application of mindfulness to work

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within the framework of that given model, resulting in three prominent approaches: Mindfulness Based Stress Reduction (MBSR) (Kabat-Zinn, 1979), Mindfulness Based Cognitive Therapy (MBCT) (Williams & Teasdale, 2002) and Expressive Therapies.

### **Mindfulness Based Stress Reduction (MBSR)**

Mindful Based Stressed Reduction (MBSR) was originally developed by Jon Kabat-Zinn (1979) as a result of working in a clinical setting with patients with physical chronic pain. Through his work Kabat-Zinn realized that mindfulness was effective at treating a wide variety of diagnoses, including mood disorders like depression and anxiety as well as helping to reduce stress that often exacerbates these diagnoses (Baum, 2010). Kabat-Zinn's' approach to mindfulness is now being used in 250 major hospitals in the United States (Baum, 2010).

The theory behind MBSR stresses the importance of the mind body connection and meditation, that can be applicable to both group and individual settings, ideally implemented over an eight-week period (Rodrigues et al., 2017). MBSR is a popular approach to treatment due to its efficacy across age populations (Rodrigues et al., 2017; Samira et al., 2019; Serpa, Taylor & Tillisch, 2014; Zhang et al., 2014). MBSR was shown to be useful in treating psychological health (Zhang et al., 2019), depression and anxiety (Samira et al., 2019) as well as suicidal ideation (Serpa et al., 2014).

A study done by Zhang et al. (2019) measured the psychological effects of MBSR on adolescents with subthreshold depression and whether it would be beneficial in several domains. The study found that MBSR had a positive effect on the adolescent's psychological health, evident by a reduction in depressive symptoms including rumination and mood. Furthermore, the study showed an increase in cultivation of mindfulness which continued to persist for three

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months following the implementation of the intervention (Zhang et al., 2019). The fact that the effects of the mindfulness intervention were present at a posttest duration of three months indicates the possibility that Mindfulness as a coping skill becomes easier to access following an intensive training regimen.

Another MBSR study by Samira et al. (2019) explored the relationship between depression, anxiety, quality of life in Iranian women and examined how MBSR may be able to affect these aspects. Each aspect was measured using a different battery of tests. Levels of depression were examined using a Beck Depression Inventory (BDI). Anxiety levels were calculated using the Itemized general anxiety disorder scale (GAD-7), and lastly a quality of life questionnaire (PWI-A) was used to determine satisfaction of the individual's life (Samira, et al., 2019). The study found that MBSR can not only provide a reduction in levels of anxiety, but also provided an increase in their perceived quality of life (Samira et al., 2019). This study indicates that Mindfulness can be a useful tool not only for reducing or treating psychiatric components such as anxiety, but also for improving the mundane, such as how individuals perceive their quality of life. While the Samira et al. (2019) study showed a reduction in adverse symptoms and an increase in quality of life, the participants involved were not suffering from symptoms of high acuity. Therefore, there is still a need to examine if mindfulness can be used in higher levels of care.

MBSR has also been shown to include a reduction in more acute symptoms related to mental illness. One such example is a study exploring the relation to mindful based stress reduction and suicidal ideation (Serpa, Taylor & Tillsch, 2014). Serpa et al. (2014), found that the standard eight-week treatment course of MBSR caused a decrease in suicidal ideation as well

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as a decrease in co-occurring generalized anxiety. The findings of this study show that MBSR can be used in treatment with acute symptoms of psychiatric disorders. Additionally, the findings of the Serpa et al. (2014) are congruent with that of Samira et al. (2019), revealing that MBSR can have a decrease in anxiety, as well as other co-occurring depressive symptoms. The findings of the Serpa et al. (2014), Samira et al. (2019), and the Zhang et al. (2019) study indicate the efficacy of MBSR across a variety of populations including, gender, age, nationality, and career. Lastly, these studies are relevant to my thesis as suicidal ideation and anxiety are both symptoms that may be present in individuals in an inpatient setting. This fact is important to note because it is possible that both symptoms may be present in certain members of my study.

Becoming aware of and acknowledging the connection between our physical body and mental state is unique to MBSR. I will now proceed to describe additional approaches of therapeutic mindfulness that highlights the gap between our cognitive thought process and how we perceive it.

### **Mindfulness Based Cognitive Therapy (MBCT)**

MBCT was developed by Zindel Segal, Mark Williams, and John Teasdale (2002). MBCT is a great example of modifying the idea of mindfulness to work within a new therapeutic framework. MBCT is the result of taking Kabat-Zinns'(1979) MBSR and infusing it with elements of Cognitive Behavioral Therapy. While MBSR aims to de-stress and thus alleviate symptoms (physical or mental) through active steps like meditation, the focus of MBCT is to reduce the occurrence of relapse, particularly in depression and anxiety (Segal, Williams & Teasdale, 2002). Therefore, MBCT requires an individual to either be in a more stable place of functioning or at a certain level of cognitive ability (Segal, Williams & Teasdale, 2002). MBCT

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approaches mindfulness and mental illness by not proposing behavioral interventions or change strategies, but by acknowledging that thoughts are just thoughts and not facts (Wong, et al., 2011). This idea of acknowledging and accepting counters ruminating thoughts and potentially lowers the levels of stress associated with them (Frostadottir & Dorjee, 2019).

MBCT, while still an emergent approach to mental health and mindfulness stands out more than the other approaches largely due to the fact of its accessibility and ability to be self-directed once understood. This idea was also reflected in a study that imported the practice and psychoeducation of Mindful Base Cognitive Therapy to individuals experiencing depressive symptoms via an online platform called Mindful Mood Balance (MMB) (Boggs, et al., 2014). By using an internet platform, the researchers were able to minimize the cost of treatment that is normally associated with seeing a therapist. Boggs et al. (2014) found that the use of the online platform increased accessibility to mindfulness-based skills, additionally many of the participants expressed satisfaction in their experience of meditation, as well as a slight decline in presenting depressive symptoms (Boggs et al., 2014).

Another study found that MBCT may be efficacious to those with treatment resistant depression (Eisendrath et al., 2014). Eisendrath et al. (2014), compared the effects of MBCT and pharmacological treatment for preventing relapse against a control group receiving Health Enhancement Programs (HEP) and pharmacological treatment. The study found that the experimental group that engaged in MBCT was more effective at reducing depressive symptoms than the control group and the experimental participants were less likely to have a relapse (Eisendrath et al., 2014). This study indicates and supports the idea that Mindfulness can be

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adapted and used effectively as a supplemental component to the typical treatment of Depression.

Social interaction may be an effective skill in treating depression, but social interactions also can be a source of anxiety for many (Hallgren et al., 2017). A study conducted by Britton, Shahar, Szepsenwol, & Jacobs (2012) aimed to explore the levels of emotional reactivity to social stressors. The study measured the outcome of fifty-two individuals with diagnoses of partially remitted depression in an eight-week MBCT group, in comparison to a waitlist group that received no MBCT training (Britton, et al., 2012). The study showed that the individuals in the MBCT group were able to display a reduction in emotional reactivity to everyday stressors. In addition, the study found that even though the participants may have presented with a negative external expression, they still reported a decrease in emotional reactivity (Britton et al., 2012). These findings are relevant to my thesis, because it is my belief that art may offer a social interaction without the stressors commonly associated with social interaction. Art may allow people living with depression to be social in a group setting without the need to speak since the focus would be on the art making. Inasmuch that the art becomes a language unto itself.

The study by Britton et al. (2012) reinforces an idea that is highly present in MBSR (1979):, that often taking the middle path of acknowledging our thoughts, emotions, and responses before acting leads to a more calm and clear response (Baum, 2010), and thus potentially reducing less of the negative symptoms associated with mood disorders such as anxiety or rumination.

When speaking of MBCT, there are several things that are paramount to note. The first deals with the notion of acknowledging our thoughts, emotions, and responses is congruent with

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the concept of the middle path that is present in the Buddhist tradition, particularly that of the Mahayana tradition (Kang & Whittingham, 2010). Secondly it is important to note that it is my perception that many of the coping skills taught in MBCT are just that, coping skills. The practices used in MBCT may help alleviate symptomology, but they are not a cure all for a diagnosis of mental illness. In addition to this MBCT requires a level of buy in. The patient must first believe the idea that thoughts (intrusive, negative, or ruminating) are a symptom of a diagnosis and not a factual reality. Unlike MBCT the arts aren't necessarily as cognitive and therefore maybe more generalizing to a larger population. Art has shown to be a powerful tool for change in a variety of different fields.

### **Brief History of Expressive Therapies**

Expressive therapies act as an umbrella term that covers a variety of modalities, including art, music, dance and drama. Malchiodi (2007) states each of these modalities offers itself to serve a variety of issues within mental health. For example, Art therapy is useful for heightening the process of individuation, reflection and the reduction of anxiety (American Art Therapy Association, 2004). While today the validity and use of arts in therapy is more common it has come a long way.

Art has a long and varied history of serving a higher purpose other than simple aesthetic values (Rogers, 1993). Many well-known artists living with mental illness have utilized the arts as way of depicting their inner world and struggles to outside world (Rustin, 2008). Van Gogh, Francisco Goya, and Mark Rothko to name a few were all artists, who had used the arts to not only depict their experience of mental illness but also found the process of creation to be a brief reprieve from the struggles and symptoms of mental health (Rustin, 2008). Furthermore, many of



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these artists were practicing what may be considered Art Therapy in a modern context (Rustin 2008).

Knill, Barba & Fuchs (1995) took this concept even further back by saying that engaging in art has been a crucial part of healing throughout human history and each culture utilized it differently. The Egyptians suggested that mentally ill individuals engage in creating art as part of their treatment (Fleshman & Fryear, 1981) and the ancient Greeks used theater due to its cathartic nature (Gladding, 1992). During the 20<sup>th</sup> century the arts were noted as being used to treat difficult populations. Soldiers returning from WWI were fond of painting and making music instead of the traditional “talk treatment” as it gave them an avenue to externalize their internal experiences and relate to others (Malchiodi, 2007). Given these observations, McNiff noticed that since the arts have been continually used in the treatment of suffering individuals than it is possible that the arts can act as a form of medicine (McNiff, 1992).

There is a vast amount of research supporting the efficacy of the expressive arts in addition to traditional psychiatric care. A study done by Flett et al. (2017) found that by having individuals color or free draw resulted in a reduction of depressive symptoms as well as anxiety. While using the arts can help to reduce negative symptomology, there is also evidence showing that working in an art modality has benefits for both the therapist and the patient. A qualitative study done by Zubala et al. (2014) found that “while verbal communication has an important role in therapy, creative expression and communication through arts media adds a valuable dimension to the process” (Zubala et al., 2014, p.542). This is of crucial importance because it not only highlights how therapists can use visual art to gain background information on clients, but also how visual art can help to make the unseen- seen. By having a client engage in art making the

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therapist is inviting them to express themselves openly and honestly without judgement.

Additionally, this study found that art making not only allows for further understanding between patient and therapist, but that it allows for patients to have greater connection to communities that are engaged in the process of creating (Zubala et al., 2014)

While creating art can help to provide insight and clarity, a study conducted by Kaimal et al. (2017) sought to explore the neural pathways involved in the creation of art. The study measured the pathways activated during doodling, coloring, and free drawing. The art activities were shown to activate the medial prefrontal cortex, the section of the brain associated with reward response (Kaimal et al., 2017). Kaimal et al. (2017) found that all three categories activated the neural reward pathways, and that participants reported a positive feeling of having a good imagination, ability to solve problems, and having good ideas. These findings also bolster the study done by Flett et al. (2017) collectively showing that art can be a potent tool for the treatment of mental illness. This is crucial information because it shows that engaging in art may also serve to increase an individual's sense of self-worth. These findings can be applied to the practice of mindfulness because an individual who feels they can solve problems and can generate good ideas may be more willing to practice a more abstract technique such as mindful meditation.

In addition, it has also been found that when individuals in a clinical hospital setting view artwork with some direction provided, it has a positive effect and increases mood (Ho et al., 2015). The challenge is finding ways to sustain the increase in mood (Ho et al., 2015). It is my belief that in order to continue the increase of positive association, one should engage in the

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process of creation, in any format. This personal belief is bolstered by the findings of Kaimal et al. (2017).

Natalie Rogers (1993) refined and created directives that could be used in therapy with any population. To this day, expressive therapies are used in a variety of settings and are even being incorporated with mindfulness practices and theories.

### **Mindful Applications of Expressive Therapies**

Natalie Rogers used mindfulness in practice by minimizing inner judgement surrounding the self and client's made art (Rogers, 1993). The use of mindful creation offers clients the opportunity to be open to the present moment and to focus on the sensation of creating something. Being attuned to the action of creation then allows the art to inform the individual on the meaning of the work (Rogers, 1993). While Rogers may have been one of the first people to use mindfulness in this sense, the therapeutic applications of the arts as a form of treatment have been long standing in the world of therapy.

The studies done by Zubala et al. (2014) and Flett et al. (2017) highlights an important aspect of why the arts are helpful in the treatment of mental illness and incorporate mindfulness. Zubala's et al. (2014) study showed that engaging in art making brought an attention to the client's sense of self without judgement. This same process is reflected in Mindfulness. Mindfulness requires the participant to come to a simple awareness of the present moment without judgement (Nilsson & Kazemi, 2016). To expand on this thought, Nilsson & Kazemi (2016) posit that there are five core elements of mindfulness. By utilizing the arts alongside mindfulness, it implements four of the five; present-centeredness, attention and awareness, cultivation, and external events (stimuli) (Nilsson & Kazemi, 2016). Therefore, if previous

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studies have shown efficacy in the sole use of mindfulness in the treatment of mental illness, and previous studies have shown a beneficial outcome with the use of arts in mental health (Flett et al., 2017; Kaimal et al., 2017; Rustin, 2008; Zubala et al., 2014;), it seems that the combination of the two would serve as a positive option in the reduction of symptomology for mental illness that effects mood.

### **Method Development**

The development of the intervention began three weeks prior to first implementation of the directive. Since the aim of the directive was to examine the influence mindfulness and art might have on mood, I observed groups that involved focused elements of mindfulness, such as Dialectical Behavioral Therapy, Acceptance Commitment Therapy, and Cognitive Behavioral Therapy for mindfulness. The intent behind this was to see how patients responded to Mindfulness in a purely theoretical, cognitive and skill-based way. The primary takeaway from these observations was that patients seemed to enjoy the actual implementation of meditation, presumably over a lengthy discussion.

Additionally, prior to implementing my directive, I had already been consistently running Expressive Therapies groups on the unit and had some idea on how different groups responded to varying directives and mediums. I have noticed that often patients were more likely to engage and be focused on directives that were self-oriented and expressive, rather than cognitive, thinking based directives.

These observations informed me in creating a directive that attempts to ground patients in the present moment through the process of meditation, and to encourage participants to this mental state of meditation through a physical expression of art.

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Following these observations much consideration and discussion happened between my site supervisor and I regarding the best possible way to implement the wording, execution, and transition from meditation to art. Discussion around how to make an open-ended art task that does not feel overwhelming was an essential conclusion drawn from these discussions. In order to make the meditation feel low stakes and easy to attempt, regardless of previous history or skill level with meditation, words like “gently”, “kindly”, and “slowly”. were used when asking participants to focus on the present moment, breathing, or thoughts.

Additionally, my supervisor and I both agreed that it was essential to give a brief introduction to both expressive therapies and mindfulness, stressing several major points. The first point to stress regarding expressive therapies, was to focus on the feeling of creation rather than aesthetic end results. The main point to be stressed with mindfulness was that it is normal and natural for the mind to wander during meditation. To address this, we decided to use the phrase "when your mind starts to wander" instead of "if your mind starts to wander" to stress that a wandering mind is a consistent part of meditation. A total of ten minutes was determined to be an engaging, but not excessive amount of time for patients at this level of care to focus on.

Lastly, the selection of artistic medium was crucial. As mentioned, before I wanted the art medium to be engaging mentally and physically, as well as to draw patients into participating. In order to achieve this watercolor seemed to be a natural choice, since watercolor is a rarely used medium on the unit and many patients had vocalized previously enjoying using it. Through the discussions with my supervisor we determined that if we were able to involve multiple senses in the activity it may provide a more integrated grounding experience. To this end, the hospital ordered extra metallic watercolors which shimmer when applied, and create a galaxy looking

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effect in the water cup used to clean brushes. Additionally, watercolors, when applied with a wet edge, move through the paper and water, providing a sense of movement. Furthermore, the hospital also ordered high quality watercolor paper, which offers a physical tactile texture. In a trial run, patients also expressed some discomfort in the silence of painting, to account for this and increase levels of relaxation, calming background music was played through my phone in all following sessions. The last measure taken to ensure that the tasks offered weren't overwhelming, a circle the shape of a paper plate was traced onto all sheets of paper to provide patients with a starting point for their artistic response.

### **Participants**

Participation in my group was open to all patients on the unit who wished to attend. Due to the open nature of this group, the study includes a variety of clinical diagnoses outside of those that directly relate to mood disorder. The diagnoses included, but were not limited to, Post Traumatic Stress Disorder, Major Depressive Disorder, Obsessive Compulsive Disorder, Borderline Personality Disorder, and Generalized Anxiety Disorder. As will be further discussed, the wide variety of diagnoses incorporated in my study may have played into the results sections.

In order to ensure confidentiality and anonymity, when recording responses and attendance participants were given a letter and number related to the session and number of people in session. For example, a participant who was the first in the room of the first session would be written in the researcher's journal as ptA1, and so on in sequential order for each session.

All participants were asked to show up to group at least five minutes prior to the start of the session to minimize interruption of the group meditation. Participants were also asked to

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silence phones or turn them off completely to minimize interruption as well. Before starting the meditation, all participants were reminded to prioritize their own mental health and wellbeing and to step out of session at any point if needed. Additionally, all participants were informed and aware of the research in process, and verbally consented to participate.

### **Materials**

As mentioned in the method development there were a total of five materials used in the session. The materials used consisted of watercolor paint, brushes, watercolor paper, a Styrofoam water cup and paper towel to clean the brushes when needed. The watercolor paper was high quality artist grade paper, measuring 11” x 15”. On the paper a circle was traced onto the center, the size of a large paper plate. In terms of brushes each participant was asked to select whatever brushes they felt they would suit them best. The brushes consisted of fan brushes, flat brushes, fine point brushes, round brushes, and bright brushes. Lastly each participant had their own water cup for their brushes, so they did not have to get up in order to clean their brushes. Participants also had several sheets of paper towel adjacent to the water cup to dry their brushes when needed.

### **Directive Procedure**

Before the sessions began an announcement was made over the unit loudspeaker, informing the patients of the group that would be happening for that hour. The group sessions were either held in the art room or the dining area depending on which unit the session was being conducted on.

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At the beginning of each session, each participant was asked to introduce themselves and answer three questions: (1) what is your name? (2) If you had to rate your mood and anxiety on a scale of one to ten, with one being awful and ten being great, how would you rate it? And finally, (3) if they have ever used mindfulness before. As participants answered questions, I would record their responses in my own researchers' notebook.

After going through introductions, participants were told that we would start with a mindful grounding meditation before starting to paint. At this time the calming background music was started. Participants were guided through the meditation for about ten minutes, with a focus on breathing and relaxing in the moment. The last prompt given was to imagine a color that the participants found soothing and visualize their breath as that color. At the end of the ten minutes participants were instructed to slowly move their attention to the art supplies. Upon picking up the brushes the participants were told to use the color they had visualized to start their painting. Additionally, I instructed participants to begin their paintings in the circle that had been previously drawn on the paper.

After about five minutes of painting within the circle, I instructed participants not to be confined to our initial circle and to explore the whole space. After this prompt the only interjections I provided were prompts similar to those given in the mediation such as, “make sure you are breathing at a comfortable pace”, “when your mind wanders gently bring it back to the present moment”, and “notice how it feels to create something in this moment”.

After mindfully painting for thirty-five minutes participants were instructed to find a spot where they would feel comfortable with leaving their piece unfinished and turn their attention back to the group. After painting, the group moved to having a semi-structured discussion about



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their experiences in the mindfulness and art directive. The participants were also asked to recollect what their previous score for their mood and anxiety were and to reassess them and provide a post test score of their current levels of mood and anxiety. Their responses were noted and recorded into my researcher's journal. At the very end of the directive participants were thanked and commended for partaking in an hour of mindfulness and art, as I noted their conscious effort to participate in such an activity.

### Results

The directive consisted of a total of twenty-three participants throughout seven sessions. Of the twenty-three participants five identified as male, and the remaining eighteen identified as female (See table 1). The results and observations of each session will be reported below. The reports consist of the participants' feedback, observations from their art, and a pre and post self-reports of their mood and anxiety (for a summary of the participants' demographics and self-reports, please see table 1).

**Table 1: Participants' Demographics and Self-Reports**

			<u>ANXIETY</u>		<u>MOOD</u>	
	M	F	Pre-test M	Post-test M	Pre-test M	Post-test M
<b>GROUP A</b>	0	3	2	4	4.3	5
<b>GROUP B</b>	2	2	3	3.125	4.16	3.5
<b>GROUP C</b>	0	2	1.5	3.5	5	6
<b>GROUP D</b>	1	2	4.6	6.26	4.53	4.53

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<b>GROUP E</b>	1	2	2.6	4.3	4	5
<b>GROUP F</b>	0	1	2	3	2	3
<b>GROUP G</b>	1	6	5	5.6	4.43	5.57

**Session one**

The first session was implemented successfully and the feedback from participants was noted and recorded. The images that the participants created varied in color and pattern, but almost all stayed within the circle, all participants used shades of blue and pink in their paintings. The participants stated that they all had a previous experience in mindfulness, either in DBT or meditation, however in the discussion part, they stated that they did not find their mind wandering nearly as much during this activity, compared to the implementation of in other frameworks they had experienced. One participant stated that their mind did wander, but it was in relation to the task at hand and related to shaping the imagery on the paper. Participants stated they found the directive “centering”, “calming”, and “relaxing”. Additionally, the participants stated that they found the music helpful in relaxing themselves as well as aiding in a visualization of what to paint. One participant reported an increase in their ability to focus. All participants reported a reduction in anxiety and an increase in mood.

**Session Two**

Before this session had started, two participants came to the group thinking it was an open art group. These patients were slightly more anxious and distressed than most others in the group. When they were told about the research that would be taking place, they stated that they were not in a place to meditate and decided to opt out. Following feedback from the first session, the music was played louder to ensure that all participants could hear it more clearly. In the

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session, the participants seemed to struggle more with focusing on the task, as they had some intermittent conversation and comments despite attempting mindfulness. In their paintings, all participants again, used some shade of blue in their work. Only one of the three participants in this session had a previous experience with mindfulness, using the app headspace. The participants stated that they found their minds wandering frequently but were able to bring their attention back when the prompt to “gently turn their attention back to the present moment” was given. They also reported the same experience with their breathing, the participants shared that often they were holding their breath or breathing in a way that was not comfortable to them, and the prompts served as a reminder to do so in a manner that was comfortable for them. One participant also felt that the concept of starting within the circle was containing and wanted to immediately explore the paper. While this group reported a decrease in their anxiety, after calculating the mean scores of pre/post mood assessment, it was shown that there was a decrease in mood.

### **Session Three**

Session three provided some interesting results, largely because it was the first occurrence of someone reporting an increase in anxiety and a decrease in mood following the directive. This participant reported that they found the combination of music and prompts to be almost too much, they found the music distracting and collectively made them feel sleepy. Despite this, the participant said they might still use it as a skill but modified. The other participants all reported some slight distraction, resulting from the staff walking by and checking on which patients were in session, the ice machine in the cafeteria making noise, as well as one participant entering the room late. All the aforementioned detracted from their thought and

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creation process. Again, the one color that was consistently used was shades of blue, as well as touches of pinks across most works. All participants except the one reported a decrease in anxiety and an increase in mood.

One thing that stood out in this session was how the use of olfactory senses aided in the mindfulness directive. The group before my directive was a flower arranging group with the aim of serving as a grounding exercise. This resulted in the smell of fresh flowers throughout the unit. Due to this participant stated that the scent in the air, caused them to take longer and deeper breathes thus soothing them. One patient shared that the transition from the flower group into the mindful art was a good transition and seemed to get them ready for the art group.

### **Session Four**

Session four consisted of three participants, this may have been because the groups throughout the day had been more intensive, and by the time the three o'clock group came, patients may have been burned out from participation and were looking for a more calming activity. Additionally, I was unable to get to the watercolor supplies throughout the day, due to team meetings, and conference calls happening in the office where the art supplies are kept, because of this oil pastels were used. The prompts and script were kept the same, the only change being replacing the words watercolor and brushes with pastels. One participant in this session had previous experience with both art and mindfulness. Following the directive, the participants shared that they found the physical and tactile nature of the pastels to be grounding and helped to curb their mind from wandering. One participant drew a mandala like image using greens and reds. The Other participants drew abstract images, consisting of dashes and squiggles. They appeared very calm and focused on the task, often moving the paper away from themselves

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to get a full view of the piece. The participants reported a decrease in anxiety and an increase in mood.

### **Session Five**

There was a total of four participants in session five. However, one participant came halfway through, as such their scores were not included in mean scores, as they had not engaged in the mindful meditation. At the beginning, the participants rated their anxiety as relatively low, and the mood was overall good. This was apparent due to the lighthearted conversation and laughter that participants were having prior to beginning the directive. As the group started, they all seemed to maintain the low anxiety level which was evident by no conversation as well as a perceived and felt focus on the task at hand. However, as the session progressed two participants seemed somewhat distracted. They attributed this distraction to different reasons. One participant stated that the distraction was caused by the visual clutter of the art room. The art room has many patients made pieces on all the walls, as well as being a small space. These two factors ultimately distracted this participant from art making. The second participant reported that he was distracted due to their own overthinking and the pressure associated with making art, and their feeling that they had to create a concrete image rather than an abstract piece. This participant also stated they found their mind wandering often. Unsurprisingly, this patient reported an increase in anxiety however the mood remained the same. These two patients also appeared to stop the directive sooner than the other participants, indicating this by putting down their materials and choosing to sit with their eyes closed in the rooms.

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Otherwise all the other participants found the music and prompts helpful. Like all the other sessions the usage of blue in the participants work was apparent. The other participants reported an increase in mood and a decrease in anxiety

### **Session Six**

Session six consisted of only one participant, this participant had partaken in the directive using pastels instead of watercolors. This individual also had a previous history of using art as a hobby and mindfulness through therapy sessions. The participant stayed within the circle for much of the directive, but eventually painted outside of it, using shades of blues as well as gold and orange. The participant was visibly relaxed, apart from shaking their leg. As this participant had partaken in the previous directive using pastels, they were asked whether there was a difference in mediums and which they preferred. They responded that they preferred the pastels, as it was a more physical medium and better for expressing physically felt anxiety. They described their experience as “relaxing”, “fun”, and “engaging”. This participant reported in an increase in mood and a decrease in anxiety.

### **Session Seven**

Session six had the highest number of participants of all groups, consisting of seven participants. Some of the participants shared that they had a previous history with mindfulness and art. Additionally, this group had participants who had previously participated in one of my earlier groups. The rates of individuals mood and anxiety varied at the start, ranging from low anxiety and high mood, to high anxiety and low mood.

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The participants who had previously done the directive shared that although their mind wandered, they felt that by participating in the directive again their mind seemed to wander less. One patient stated that they found the music distracting and preferred the verbal meditation prompts that were being offered. This participant was also rocking throughout the session, which indicated either a high level of anxiety being presented physically or perhaps a self-soothing movement associated with their diagnosis. During the discussion, the participant said that the rocking is something they do while working on art projects and is part of their creative process. Throughout this session the most used colors were blues and reds.

All participants at the end reported an increase in mood and a decrease in anxiety. These findings are reflected in table 1 which outlines the demographics and self-reports of the participants.

### **Arts Based Response**

Throughout the implementation of this directive, I maintained a researcher's journal that not only contained the self-reported levels of mood and anxiety, but also my own thoughts and experiences that were occurring parallel to the participants. Based on these notes I created a piece of art that reflected my feelings and observations. The piece I created aimed to reflect the idea of how mindfulness is perceived by many, and at times myself, as a simple practice that is calming and stationary, when it is in fact a challenging exercise that requires tenacity and patience with one's self and the environment they find themselves in. Additionally, the implementation of this directive reminded me that mindfulness takes a variety of forms, such as movement, breathing, art, and interpersonal interactions. In order to reflect my findings and the

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experience of my participants I used shades of blue which was a favorite choice of many participants.



## DISCUSSION

The aim of this research was to explore the impact of mindfulness and art on individuals living with a mood disorder in a psychiatric hospital setting, through an implementation of a directive. The results indicated a positive trend in both mood and anxiety amongst the participants. Though the participants described in most cases experiencing feelings of calmness, creativity and flow, there were some participants who found the intervention challenging and



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elevating their sense of anxiety and not helpful. Both aspects, as well as next steps for research will be discussed below.

Throughout the running of my directive, it is important to note that after doing the check in and explaining that a mindful meditation would be occurring, several individuals opted not to partake in the directive, stating that “they were not in a place to meditate right now.” These participants were enacting a form of advocacy and self-care, as they explained that the meditation would be too much for them at that moment. This reflects and supports research that states that the practice of certain aspects of mindfulness is mood dependent and not related to a diagnosis (Elices et al., 2019). These participants noted that their currently elevated mood would interact with their ability to focus on the task at hand. This also aligns with the idea of present centeredness found in MBCT (Elices et al., 2019; Teasdale 2002).

Additionally, several participants found that the directive made them more anxious. These same participants also scored their anxiety high and their mood low at the pretest assessment. Furthermore, the participants had no previous experience with art or mindfulness, which may help to explain why this task felt particularly overwhelming. The anxiety of these participants may be related to a variety of issues. One explanation may be the pressure to create something that they feel has worth. Often, we are conditioned to think that the end goal of art must be aesthetically impressive to have worth (Rogers, 1993). The prompt that was given for this direct was open ended, and only asked participants to paint with color, not to depict anything, however it is possible that this open ended prompt, combined with an individuals conditioned beliefs of what art is, and their already high anxiety created somewhat of a paradox

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in which anything that was created may have been anxiety producing or not perceived as “worthy” artistically.

Inasmuch, many of the participants were able to create imagery out of their abstract color washes. These participants also had a brighter affect after the directive and were more likely to support other group members who were self-conscious of their own creation. This finding aligns with Kaimal et al. (2017), who argue that individuals who partake in art in any setting are more likely to feel that they have good ideas and can solve problems. The participants who were able to make imagery out of their abstract colors, may have also been taking the Kaimal et al. (2017) findings a step further by helping other peers to see the value in their own work, therefore projecting the importance of the artist as its creator.

This study also confirmed the hypothesis that art-based mindfulness will have an influence on mood and anxiety. Almost all participants reported a decrease in anxiety and an increase in mood (See table1). These findings support the research done by Flett et al. (2017), who showed that free drawing and coloring can result in a decrease in depressive symptoms. The study done by Flett et al. (2017) used colored pencils as its primary medium, this study used water color and one session of pastel and was still able to garner similar results implicating that any sort of drawing, regardless of medium, may be beneficial to those with depressive symptomologies.

Throughout the execution of each session, there was an emergent theme surrounding the colors participants chose to use. Throughout all sessions, the color of blue, whether a light blue or dark blue was present in works in every session. The first step of the painting directive was to visualize a color that they found calming or peaceful, this instruction left the choice of color up

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to the participants. This indicates that it may have been purely coincidental that blue was chosen, and that the association of emotion and mood to color should be based on experiment specific parameters (Fugate & Franco, 2019) and ultimately meaning making should be left to the creator (Rappoport 2009; Rogers 1993).

One important finding was the use of intermodal mediums. The group that had engaged in the flower arranging prior to the directive and the pastel participant all showed a strong decrease in anxiety. One possible reason for this decrease may be explained through the Expressive Therapies Continuum (ETC) (Hinz, 2009). The ETC proports that mediums are effective at working through different cognitive domains. Since the flower arranging requires movement and deliberate placing of items, it activated the kinesthetic level and expelled anxious energy, thus preparing the participants to engage in a perceptual task such as watercolor (Hinz, 2009). In the same line of thought, the use of pastels may be more effective to those who are highly anxious as it requires a physical exertion that watercolor lacks. This transition between mediums and groups may help to explain the strong decrease in anxiety and an increase in mood for these participants.

Some participants found the music helpful as it allowed them to switch their focus between artwork and surrounding stimuli. It was my intention to have the music serve as a relaxing background noise that helped to ease participants into the meditation. However, the level at which I initially played the music at, was too quiet for many participants, so the volume was increased. As this current study stands, more research is needed in order to understand the effect music volume plays with mindfulness and active creation.

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While this study aimed to explore the effect mindfulness and art had on mood, it didn't include only participants aimed specifically at one population. This study consisted of a variety of age, gender, and diagnosis; therefore, the findings cannot be directly generalized to clinical populations for several reasons. The first being that the sample size does not have enough power, 23 participants is a good start, but nowhere near large enough to find significant results. Additionally, the diversity in sampling in terms of diagnosis, had varying levels of acuity, and the presentation of mental illness is not uniform, so it would be ill advised to generalize findings to an overarching populations diagnosis.

Moving forward it is my hope that this research can be used to supplement and further the validation of Expressive Therapies as a clinical model. Further research is needed on the effectiveness of mediums with mindfulness, as well as research exploring how elevated mood prior to mindfulness directives effects the potency of mindfulness-based interventions.

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**THESIS APPROVAL FORM**

**Lesley University**

**Graduate School of Arts & Social Sciences**

**Expressive Therapies Division**

**Master of Arts in Clinical Mental Health Counseling: Expressive Arts Therapy, MA**

**Student's Name:** \_\_\_\_\_ Patrick MacLeod \_\_\_\_\_

**Type of Project:** Thesis

**Title:** "Calming Watercolors": Using Mindful Art in Treatment of Mood Disorders, Development of a Method

**Date of Graduation:** \_\_\_\_\_ May 5, 2020 \_\_\_\_\_

In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

**Thesis Advisor:** Dr Tamar Hadar, MT-BC